MDR Tracking Number: M5-04-1433-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 01-21-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic exercises and electrical stimulation were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 09-10-03 through 11-21-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 29th day of March 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

March 18, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was employed as a bus driver with ___. He was involved in a motor vehicle accident on ___ that resulted in injury to his left shoulder. He underwent surgery for a full thickness tear of the supraspinatus tendon and partial claviculectomy on 11/01/02. He experienced an aggravation to his condition while in therapy on 03/04/03 and underwent a second surgery on his left shoulder on 08/23/03. On 08/27/03 he was referred by his surgeon to begin post-op treatment with ___.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic exercises and electrical stimulation provided from 09/10/03 through 11/21/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

___ denied payment to ___ for the dates in this dispute based on the EOB statement "Total Billing For Physical Therapy Modalities Now Exceeds Physical Therapy Cap." On 12/08/03 President Bush signed a bill that extended the moratorium on the $1,590 Medicare therapy cap through 12/31/05. Specifically this section amended 42 U.S. C. 1395(g)(4) to read "this section shall not apply to expenses incurred with respect to services furnished during 2000, 2001, 2002, 2003, 2004 and 2005. However, more importantly TWCC advisory 2003-11 addresses the issue of the cap stating, "this advisory clarifies that in the Texas Workers Compensation system medical necessity prevails."

Also, ___ of ___ represents that the carrier's position is that the documentation does not support the medical necessity for the extended use of treatment in dispute. She then quotes Medicare guidelines stating, "The services must be of such level of complexity and sophistication or the condition of the patient be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision.

Services which do not require the performance or supervision of a physical therapist are not considered reasonable or necessary PT services." It appears that the carrier is stating that since ___ is not a Physical Therapist any documented services rendered by ___ are neither reasonable nor necessary. This is also addressed by Advisory 2003-11. A payment policy used in the Medicare program must not be utilized for Medical Fee Guidelines purposes if it will result in discrimination prohibited by insurance code Article 21.52, Section 3(d).

The carrier had a retrospective review performed on 02/19/04 by ___, a Chiropractor. ___ stated that the conservative physical medicine and rehab program was reasonable and necessary up to 10/27/03. The ___ reviewer disagrees with ___, finding the care to be medically necessary through 11/21/03 because the documentation reveals a more difficult than normal recovery time for this patient due to a re-injury and ultimately a second surgery. A course of guided therapeutic exercise for ten weeks was reasonable, in this case, to insure that appropriate biomechanics and compliance were used to increase function of this patient while decreasing the possibility of further re-injury. ___ evaluation on 11/28/03 revealed a reduction in his overall pain scale by two points from 10/27/03. On 11/28/03 ___stated that the patient had achieved and maintained normal ROM and determined him at a plateau in his recovery. He then released him to return to his work duties. Care rendered by ___promoted recovery, decreased the patient's pain and enhanced ___ ability to return to work. The care rendered by ___ was within the TCA guidelines for Quality Assurance and Practice Parameters.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,